Substance Abuse Treatment:
Improving Treatment of Co-Occurring Disorders

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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

President George W. Bush

State of the Union – January 28,2003

- "…*Addiction crowds out friendship, ambition, moral conviction, and reduces all the richness of life to a single destructive desire*."

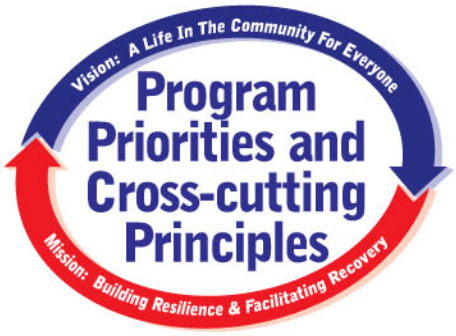
President George W. Bush

State of the Union – January 28,2003

- *"…Let us bring to all Americans who struggle with drug addiction this message of hope: the miracle of recovery is possible, and it could happen to you."*

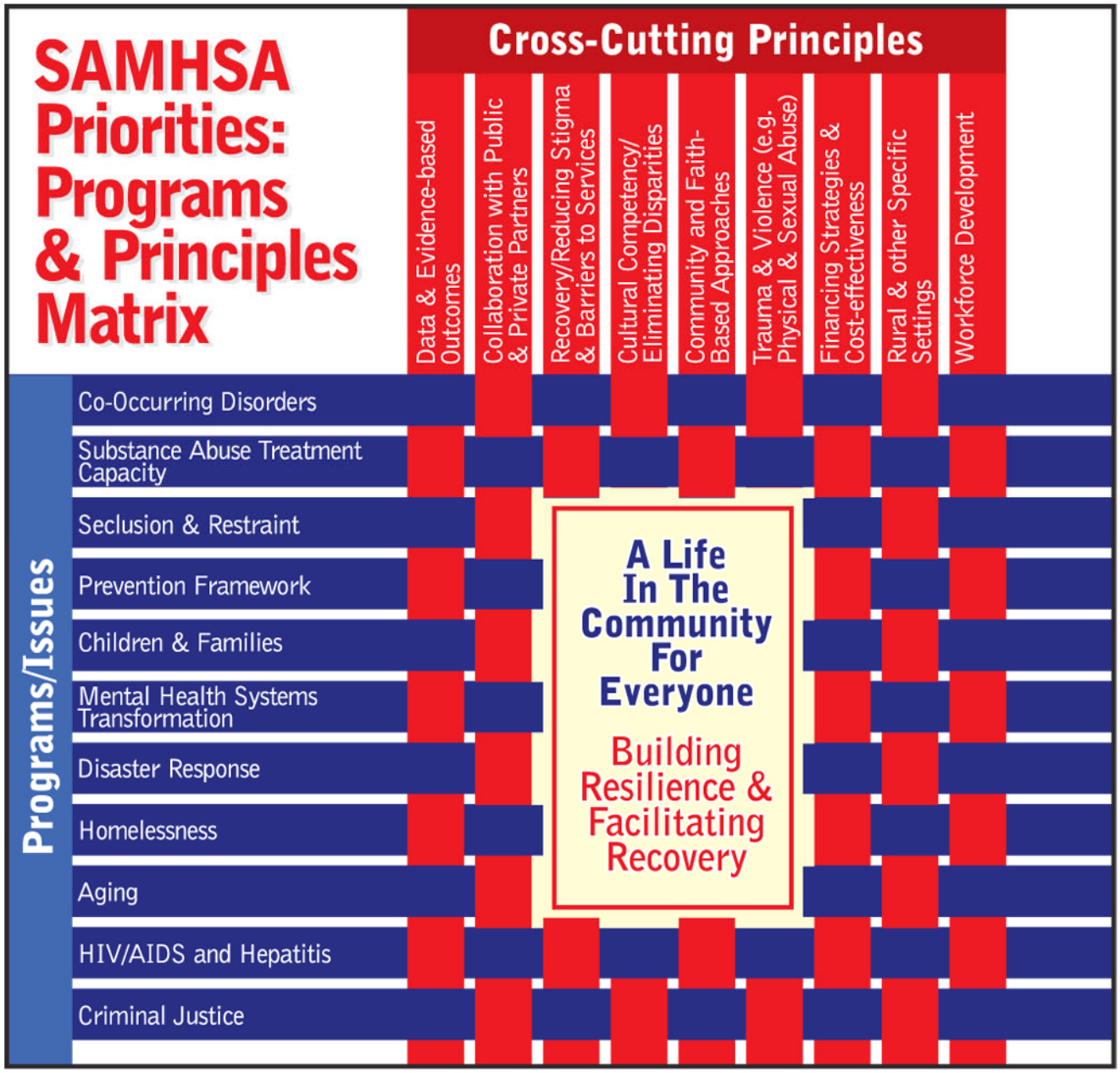
SAMHSA

- Vision: A life in the community for everyone
- Mission: Building resilience and facilitating recovery



"Built on the principle that people of all ages, with or at risk for mental or substance use disorders, should have the opportunity for a fulfilling life that includes a job, a home, and meaningful relationships with family and friends."

Charles G. Curie, M.A., A.C.S.W.
Administrator, SAMHSA



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

PARTNERS
for recovery

Partners for Recovery – Common Goals

- Improve public understanding of substance use disorders
- Enhance recognition that treatment is effective
- Share the knowledge that recovery from addiction is powerful

Partners for Recovery, cont.

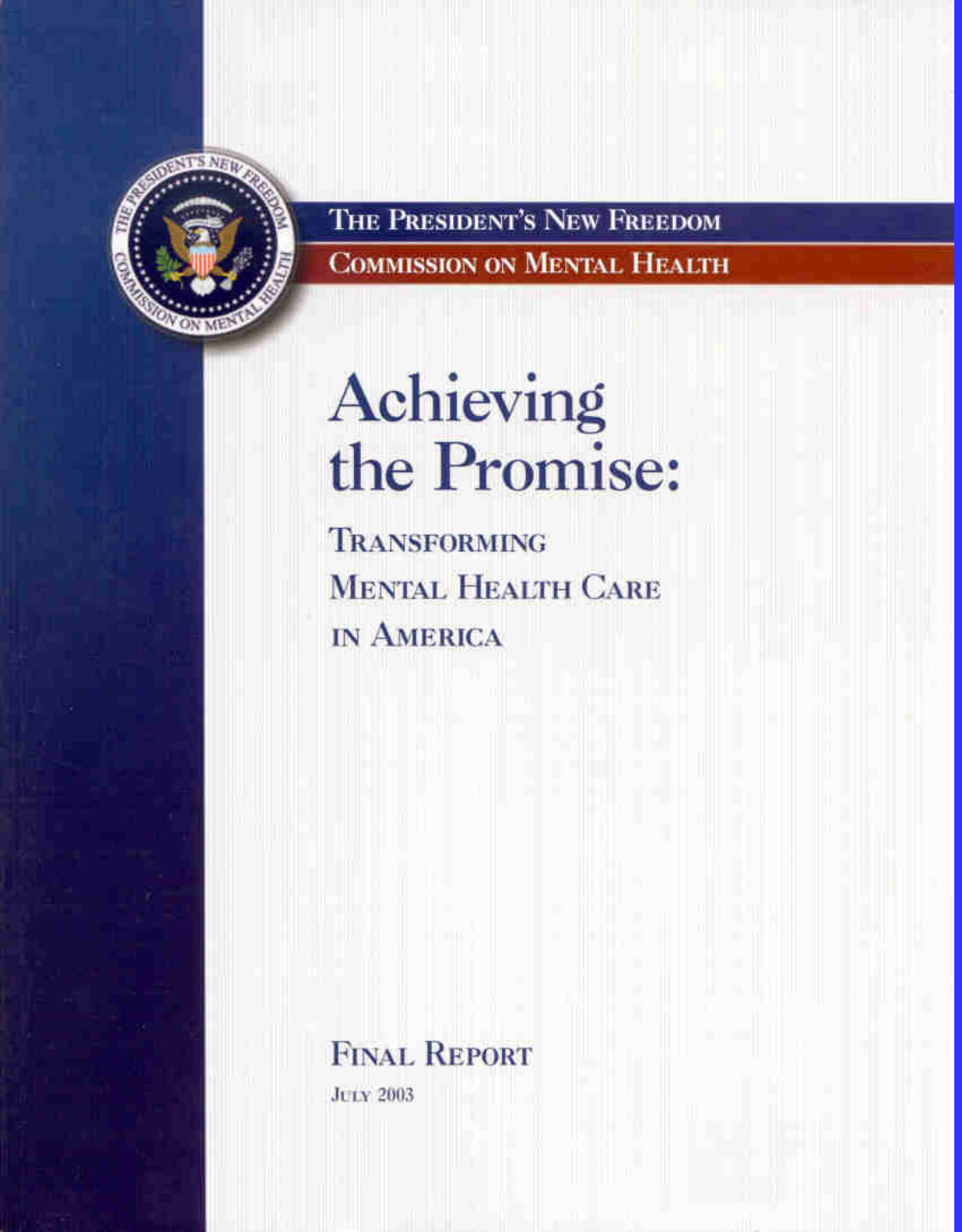
- Recovery can and does mean different things to different people
- Recovery is a personal process for which there are many pathways
- Engages more partners than ever before

Partners for Recovery, cont.

- Mental Health System
- Community-based Organizations
- Faith-based Organizations
- Primary Care Delivery System
- Criminal Justice Agencies
- Prevention and Early Intervention
- Diverse Cultures and Ethnicities
- Rural Populations

Mental Health Month
May 2004

Mental Health Matters:
In Your Life



President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America

Final Report Delivered to the President on July 22, 2003

New Freedom Commission's Goals in a Transformed Mental Health System

- Mental Health is essential to overall health
- Mental Health Care is consumer and family driven
- Disparities in Mental Health Services are eliminated
- Early Mental Health screening, assessment and referral to services are common practice
- Excellent Mental Health care is delivered and research is accelerated
- Technology is used to access Mental Health care and information

COD Prevalence Data

Prevalence of Serious Mental Illness

2002 National Survey on Drug Use and Health

- An estimated 17.5 million adults aged 18 or older with SMI
  - This is 8.3% of all adults aged 18 or older
- Rate of SMI by age range
  - 13.2% among persons aged 18-25
  - 9.5% among persons aged 26-49
  - 4.9% among persons aged 50 or older

Prevalence of Serious Mental Illness

2002 National Survey on Drug Use and Health

- Among adults the percentage of females with SMI was higher than for males
  - 10.5% for females
  - 6.0% for males

Illicit Drug Use

2002 National Survey on Drug Use and Health

- 8.3 percent of the population aged 12 years or older
- 19.5 million were current illicit drug users

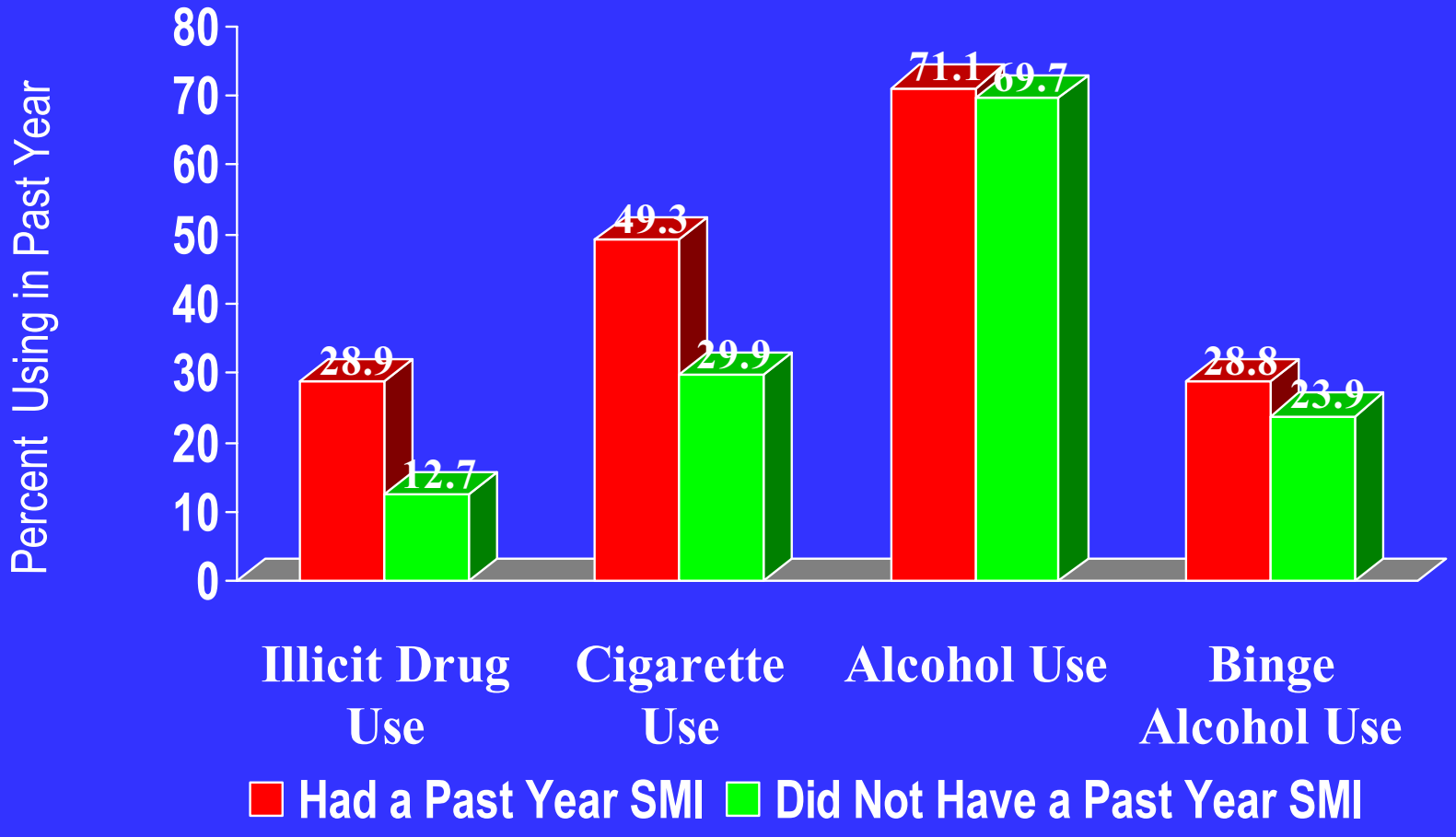
Alcohol Use

2002 National Survey on Drug Use and Health

- 15.9 million aged 12 or older are heavy drinkers
- 6.7 percent of the general population aged 12 or older reported heavy drinking

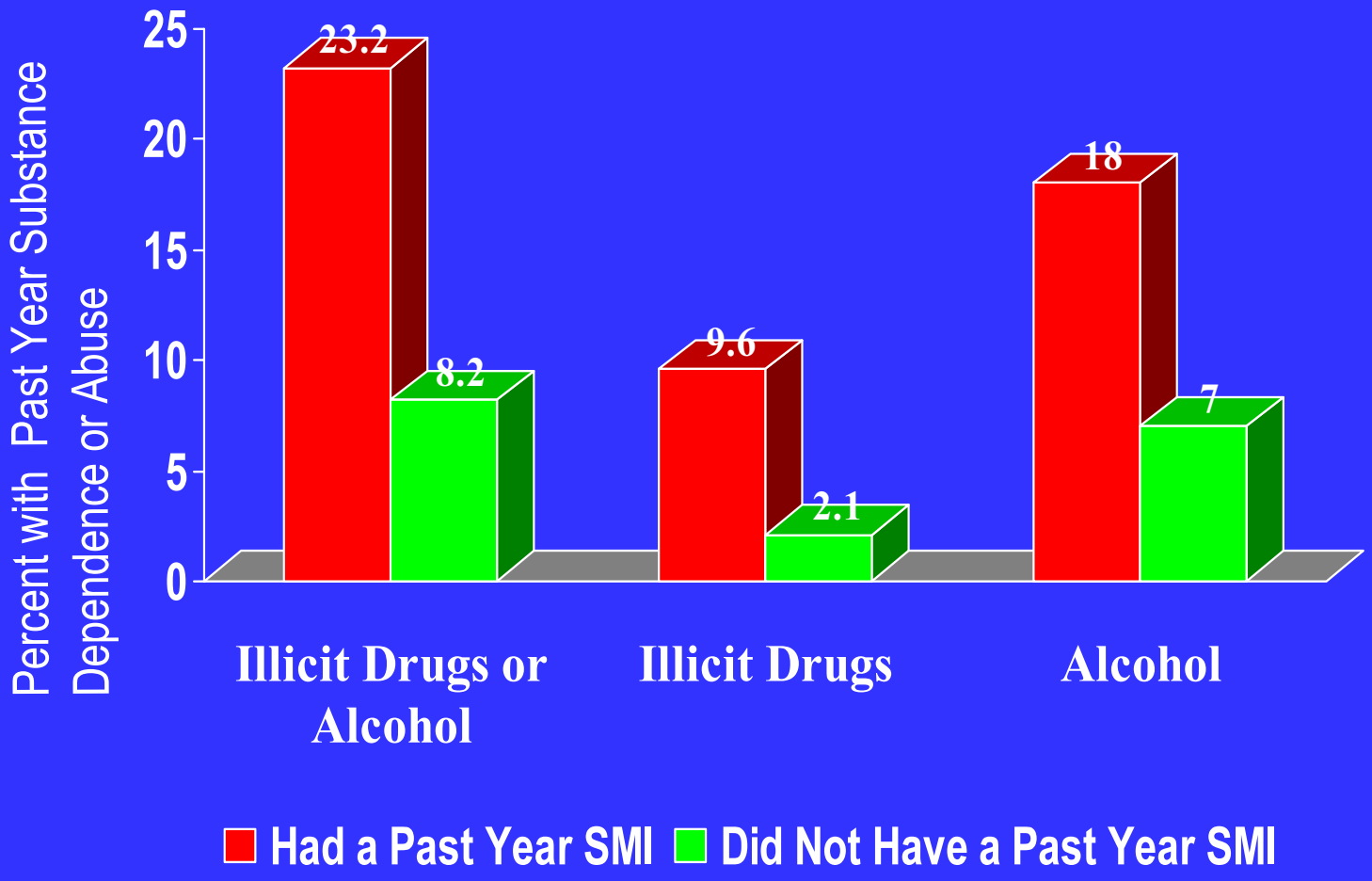
Past Year Substance Use among Adults Aged 18 or Older, by Serious Mental Illness

2002 National Survey on Drug Use and Health



Past Year Substance Dependence or Abuse among Adults Aged 18 or Older, by Serious Mental Illness

2002 National Survey on Drug Use and Health

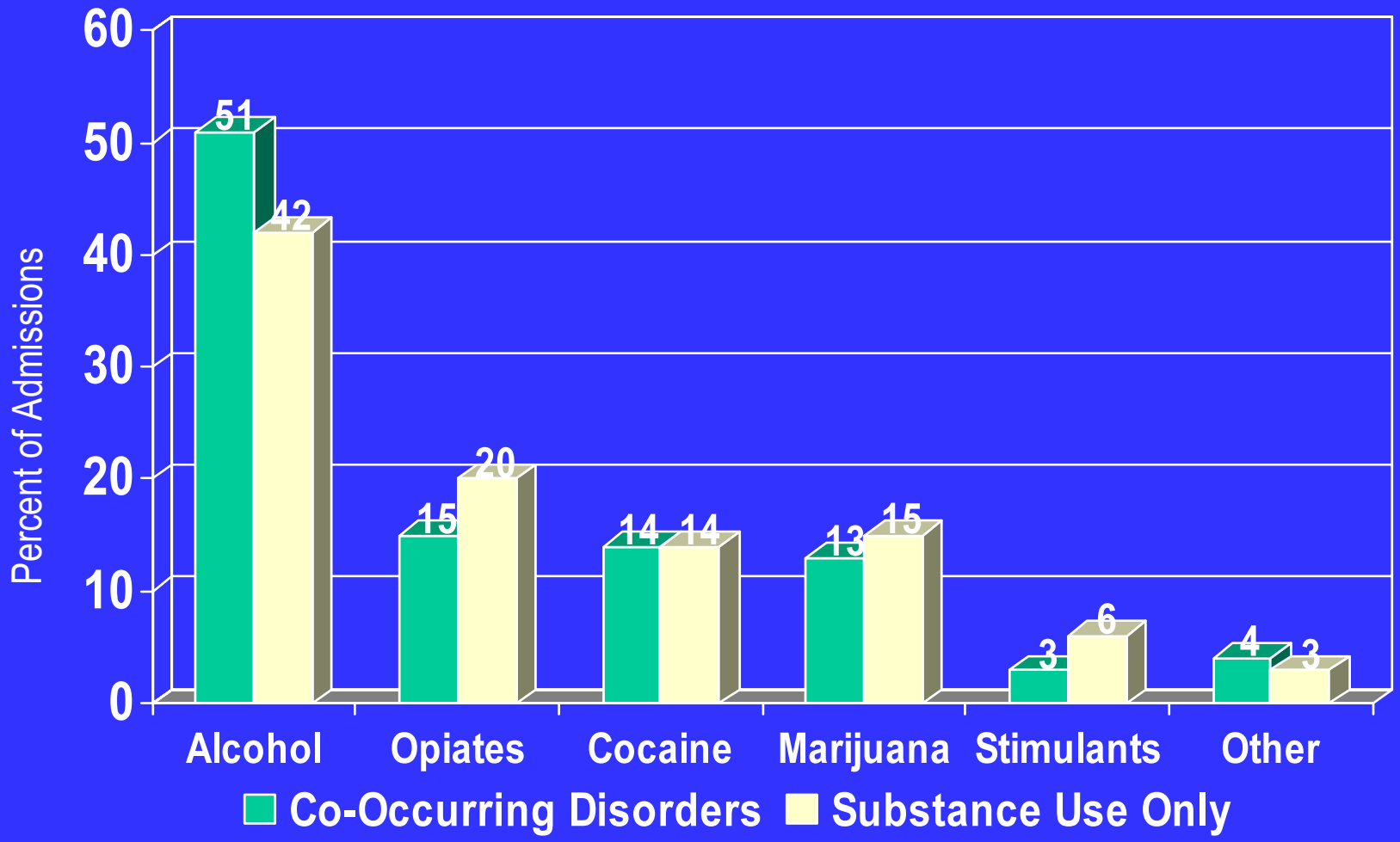


Co-Occurrence of Serious Mental Illness with Substance Dependence /Abuse

2002 National Survey on Drug Use and Health

- 4.0 million adults had both SMI and SD/A in the past year
- 0.8 million had SMI and dependent/abused alcohol and illicit drugs
- 0.9 million had SMI and dependent/abused only illicit drugs
- 2.4 million had SMI and dependent/abused only alcohol

Primary Substance of Abuse for Treatment Admissions, Psychiatric Diagnosis Status, *2000 Treatment Episode Data Set*



Cigarette Smoking and COD

- Cigarette Smoking is associated with major depression, schizophrenia and alcoholism
- “Epidemiologic Studies report an association between cigarette smoking and suicide of a magnitude similar to that of the association between smoking and coronary heart disease.”

K. Malone et al, Am J Psychiatry 160: 773-779 (2003

Smoking, COD and Burden of Disease

- Smoking places a financial burden on individuals with COD
- Majority of patients admit smoking is a problem
- Smoking places a financial burden on the health care delivery system, forcing the allocation of scarce resources for the treatment of preventable physical disorders

Behavioral Health Systems Response to Cigarette Smoking

- Despite the Availability of Effective Treatments for Smoking, Most Clinicians Do Not Routinely Offer Smoking Cessation Interventions.
- Most Behavioral Health Systems Do Not Prioritize Smoking Cessation Strategies as a Part of a Systems Response to COD

Illicit Drug Use and Unmet Need

- In 2002, 6.3 million of the 7.7 million Americans in need of treatment for an illicit drug did not get help
- Only 362,000 recognized their need for treatment
- 88,000 sought help but were unable to find care

National Comorbidity Survey

Co-occurring substance use disorders and mental disorders

- 42.7% of individuals with a 12-month addictive disorder had at least one 12-month mental disorder
- 14.7% of individuals with a 12-month mental disorder had at least one 12-month addictive disorder

Epidemiological Catchment Area Survey

- 47% of individuals with schizophrenia also had a substance use disorder
  - More than 4 times as likely as general population
- 61% of individuals with bi-polar disorder also had a substance use disorder
  - More than 5 times as likely as general population

Current Situation - *Youth*

- Nearly 43% of youth who receive mental health services have been diagnosed with a co-occurring disorder
- Alcohol or illicit drug dependence was reported by approximately 13% of adolescents with significant emotional problems
  - 17% of those with significant behavioral problems

NTIES

National Treatment Improvement Evaluation Study, CSAT

- 74% of men, 73% of women were victimized prior to treatment
- 73% of men, 66% of women were victims of physical assault
- 42% of women, 6% of men were victims of sexual assault
- 55% - 99% of women substance users report being victimized

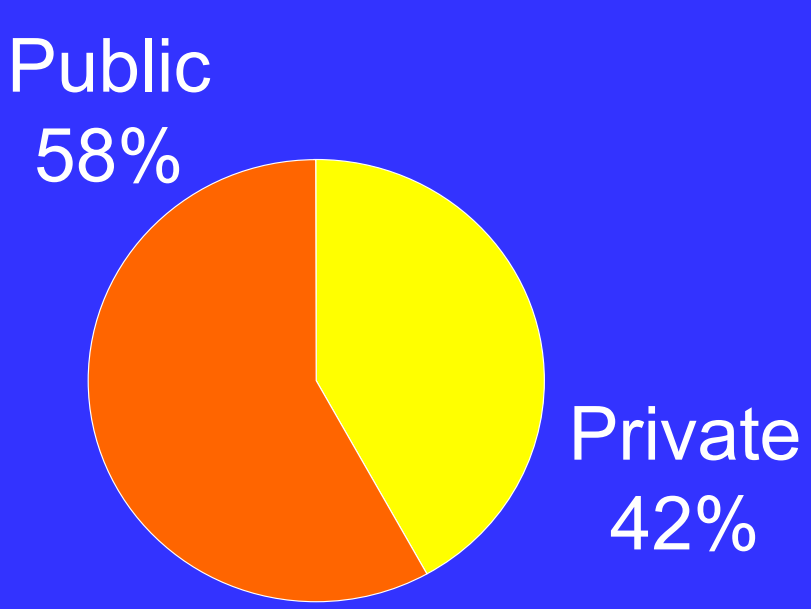
NTIES *cont.*

National Treatment Improvement Evaluation Study, CSAT

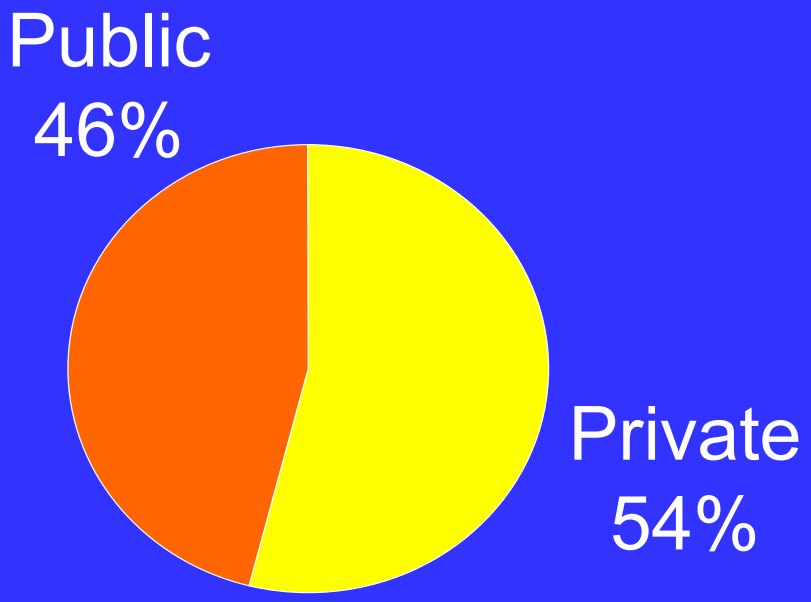
- 72% of men, 50% of women committed acts of violence
- 59% of men, 42% of women were both perpetrator and victim
- 20% were victims only
- 11% were perpetrators only
- 15% of men, 31% of women were victims only

Health Expenditures on SA and MH

MH/SU vs. All Health Funding, *1997*

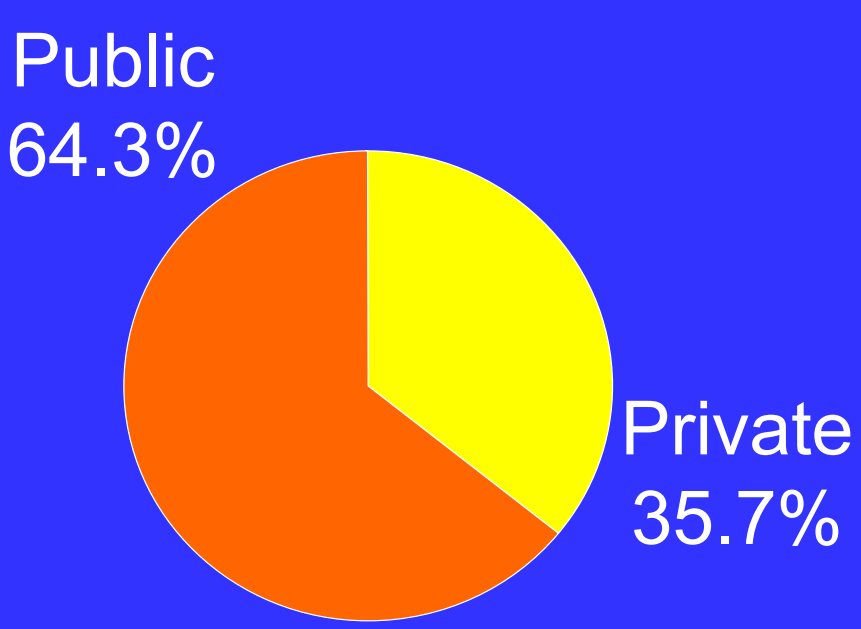


MH/SU
($82.2 Billion)

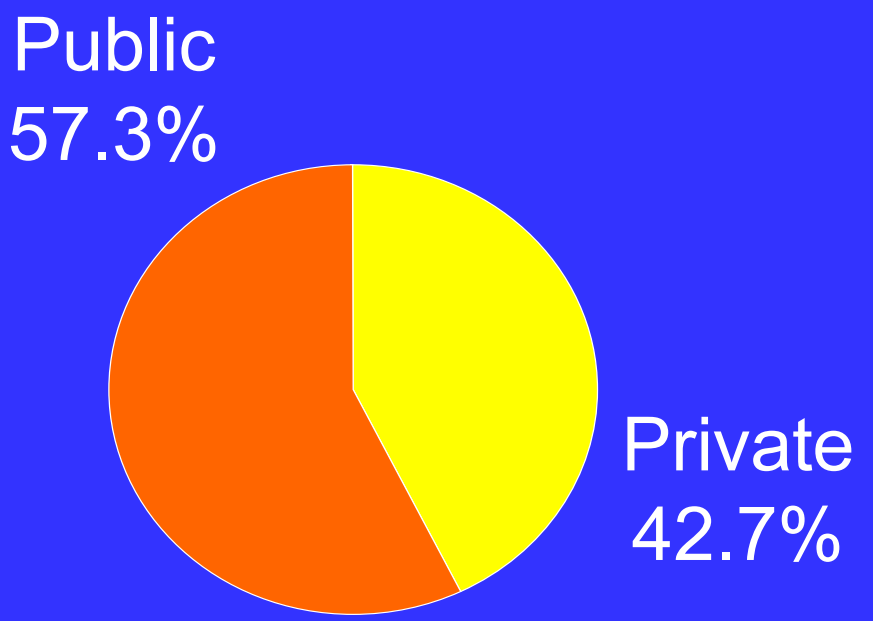


All Health
($1,057.5 Billion)

SU vs. MH Funding, *1997*

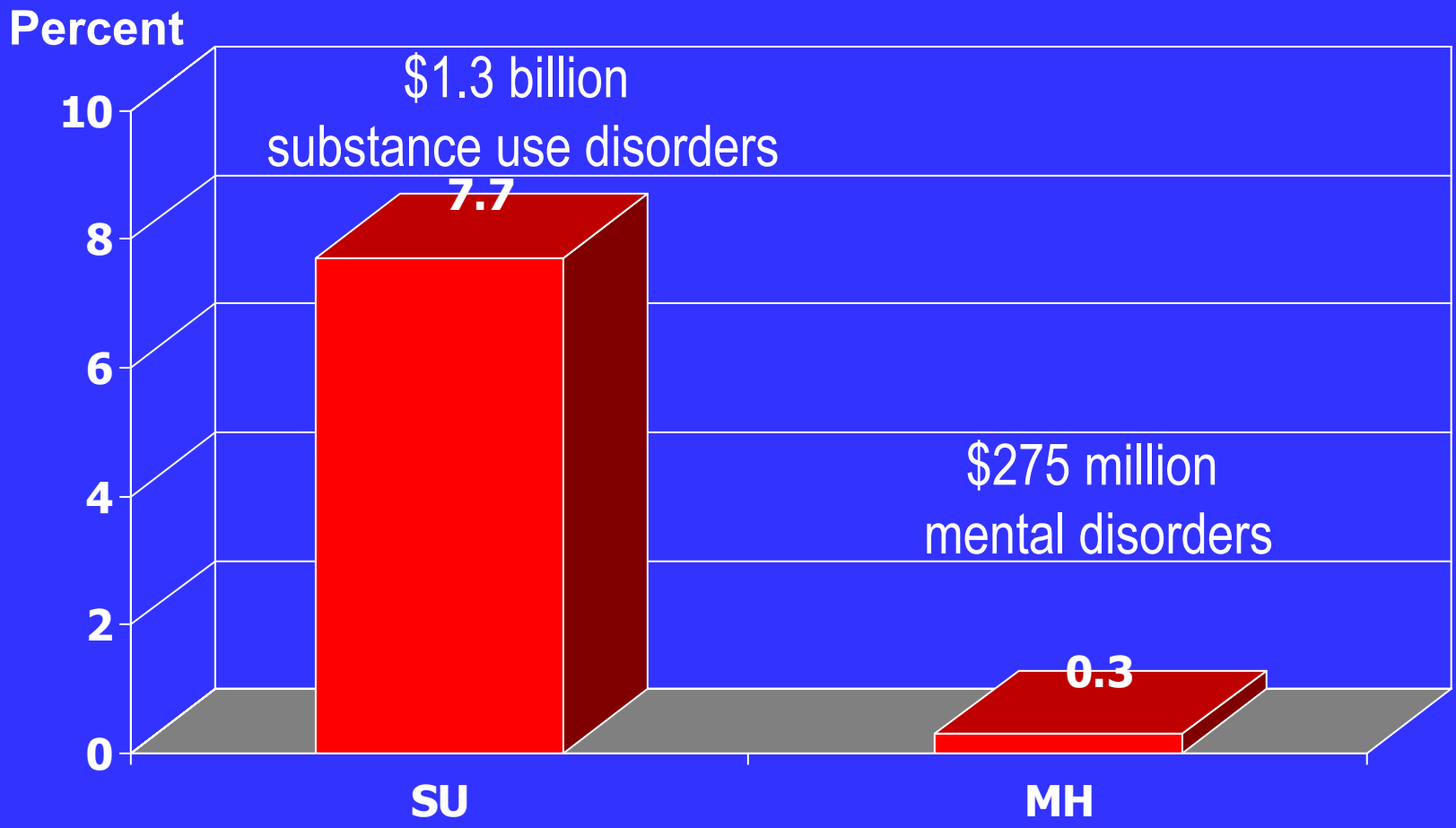


SU
($11.4 billion)

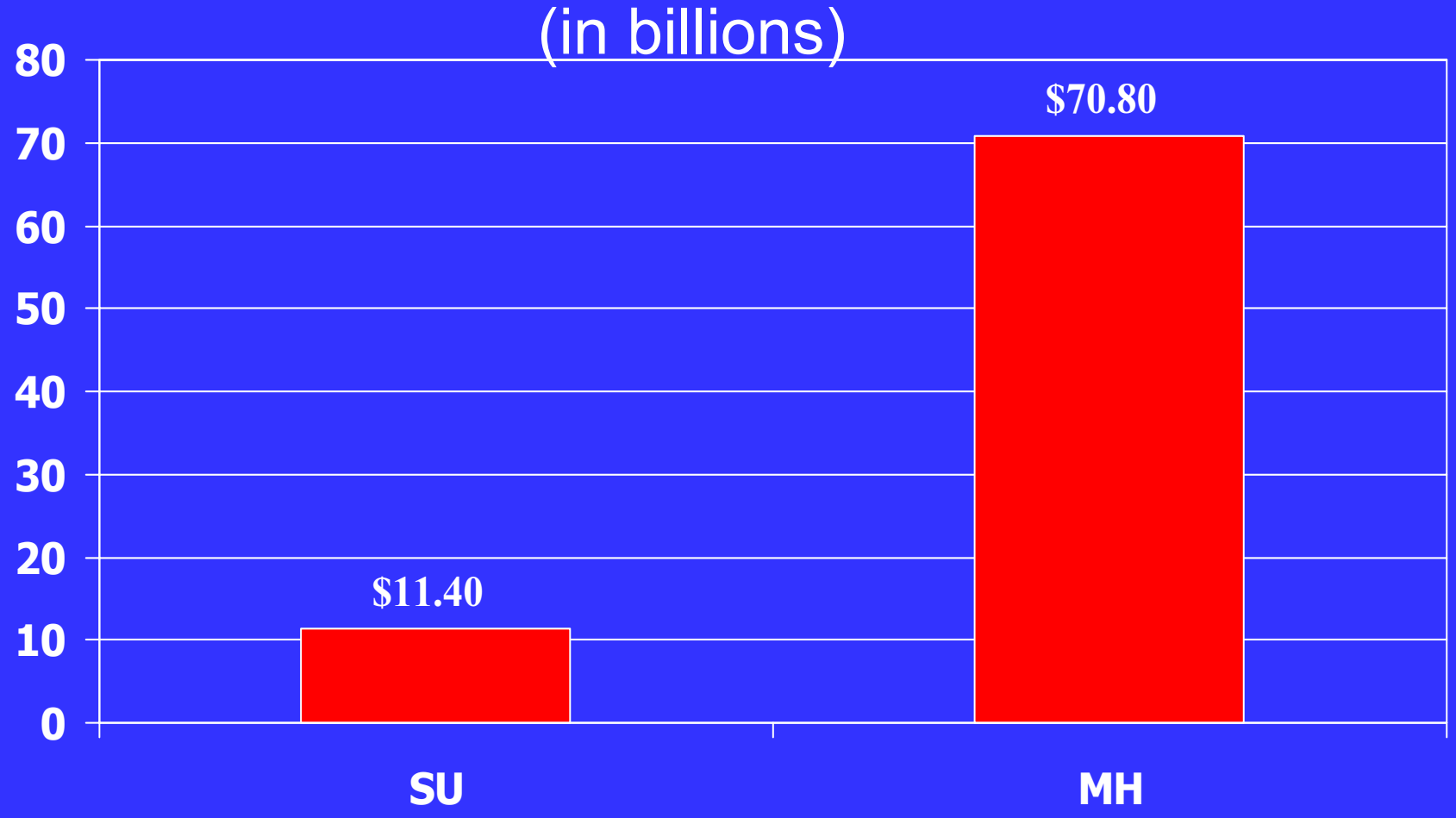


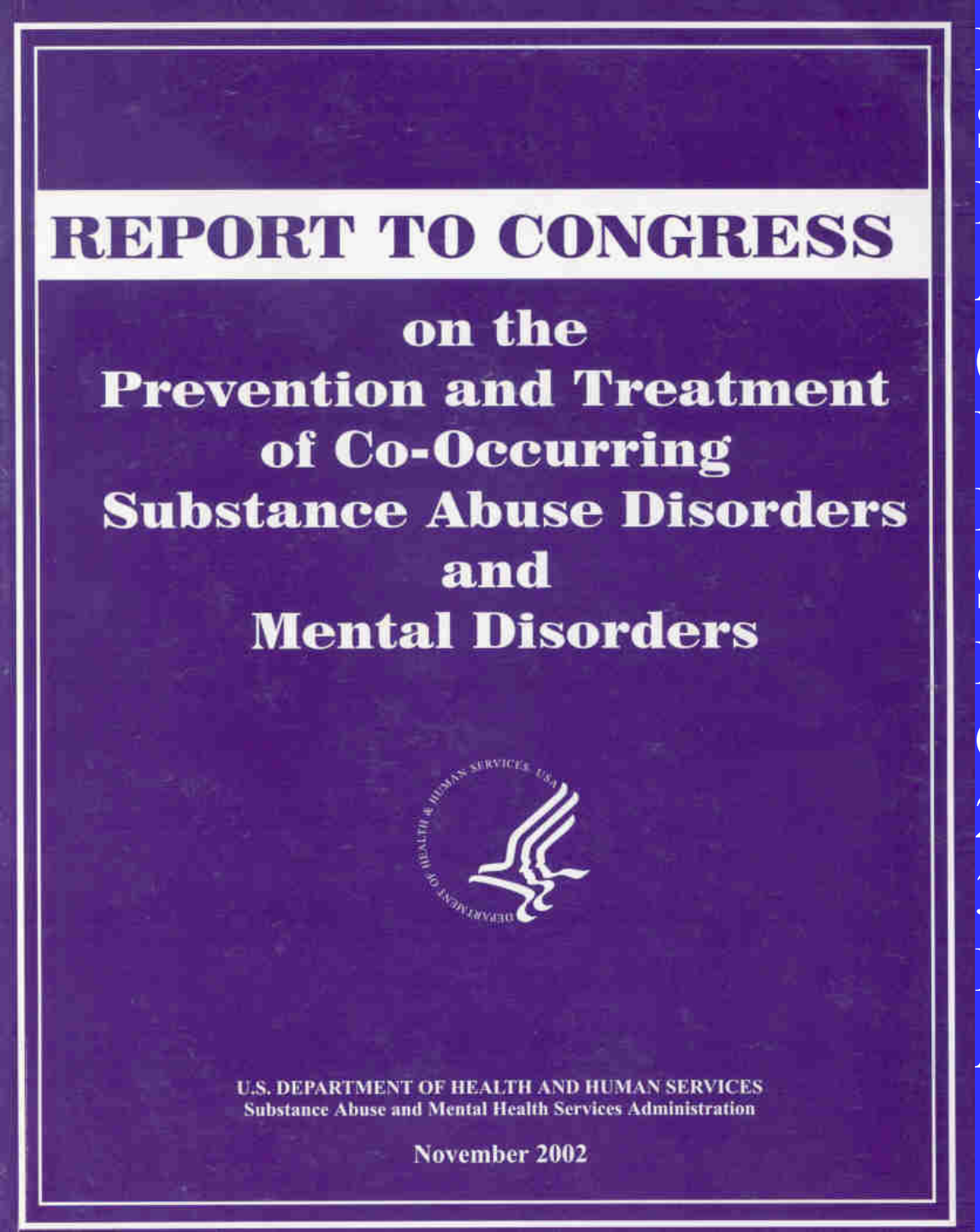
Mental Health
($70.8 Billion)

Federal Block Grant Percent of Expenditures for SU and MH Funding, *1997*



SU vs. MH Spending, *1997*





Report prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services under the Mandate of § 3406 of the Children's Health Act of 2000 (Public Law 106-310), § 503A of the Public Health Services Act.

Defining Co-Occurring Disorders

- Individuals who have at least one mental disorder as well as an alcohol or drug use disorder.

- While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of each other.

SAMHSA Report to Congress at page 2

Examples of Psychiatric Disorders Associated with Co-Occurring SA Disorders

- Schizophrenia
- Bipolar Affective Disorders
- Other psychotic conditions
- Major depression
- PTSD
- Other Anxiety Disorders
- Mild depressive disorders
- Mild organic syndromes
  - Closed head injuries
- Eating Disorders
- Anti-social personality disorder
- Borderline personality disorders

Complicating Factors

- The severity of either of the disorders
- Lack of trained providers knowledgeable about both disorders
- Lack of sufficient resources available to the behavioral health delivery system
- Lack of coordination between many state and local entities

Co-occurring Report to Congress

- Imperative that substance use and mental health service providers, constituencies and advocates bring together the respective fields
- Confront discrimination and stigma attached to people with substance use and co-occurring disorders

Co-occurring Report to Congress *cont.*

- Patients with substance use disorder and co-occurring mental disorders *can and do recover*
- Every community must have access to evidence-based treatments
- Care must be culturally competent and culturally sensitive

Co-occurring Report to Congress *cont.*

- Provides a comprehensive review of evidence-based practices for treating individuals with co-occurring disorders
- Addresses nature of prevention, program access, screening, assessment, treatment and follow-up
- “Must-have” resource for everyone

SAMHSA's Women, Co-Occurring Disorders and Violence Study

- Meet the needs of women with substance abuse disorders and co-occurring mental disorders and histories of violence
- Prevent intergenerational transfer of substance use disorders and violence
- Children's Subset Study
  - Promote adaptive behavior, resilience and social and emotional well-being for children

SAMHSA's Women, Co-Occurring Disorders and Violence Study *cont.*

- Mental health
- Addiction treatment
- Trauma
- Physical health
- Parenting skills

COSIGs

Co-occurring State Incentive Grants – Administered by CSAT and CMHS

- Screen individuals for co-occurring disorders
- Assess the level of severity
- Treat in comprehensive and coordinated manner
- Train providers to screen, assess and develop preventive interventions and treatment plans
- Evaluate impact of prevention and treatment

COSIGs *cont.*

Co-occurring State Incentive Grants – Administered by CSAT and CMHS

- $6.5 million in incentive grants available to states to develop and enhance infrastructure to improve treatment for co-occurring disorders
- Average award from $500,000 to $1.1 million per year up to 5 years

COSIG States

Co-occurring State Incentive Grants – Administered by CSAT and CMHS

- Arkansas
- Pennsylvania
- Hawaii
- Missouri
- Texas
- Alaska
- Louisiana

Center of Excellence

National co-occurring disorders prevention and treatment cross-training and technical assistance

- Bring together state-of-the-art information on prevention and treatment services, best practices, and other knowledge-based treatment and evaluation activities
- Available to COSIG states, other states and communities and individual providers

SAMHSA Science-to-Services Agenda

- National Registry of Exemplary Programs
- Addiction Technology Transfer Centers
- Centers for the Advancement of Prevention Technology
- Mental health information and technical assistance centers
- *Substance Abuse Treatment for Persons with Co-Occurring Disorders – TIP to publish in early 2004*

SAMHSA/CSAT Commitment

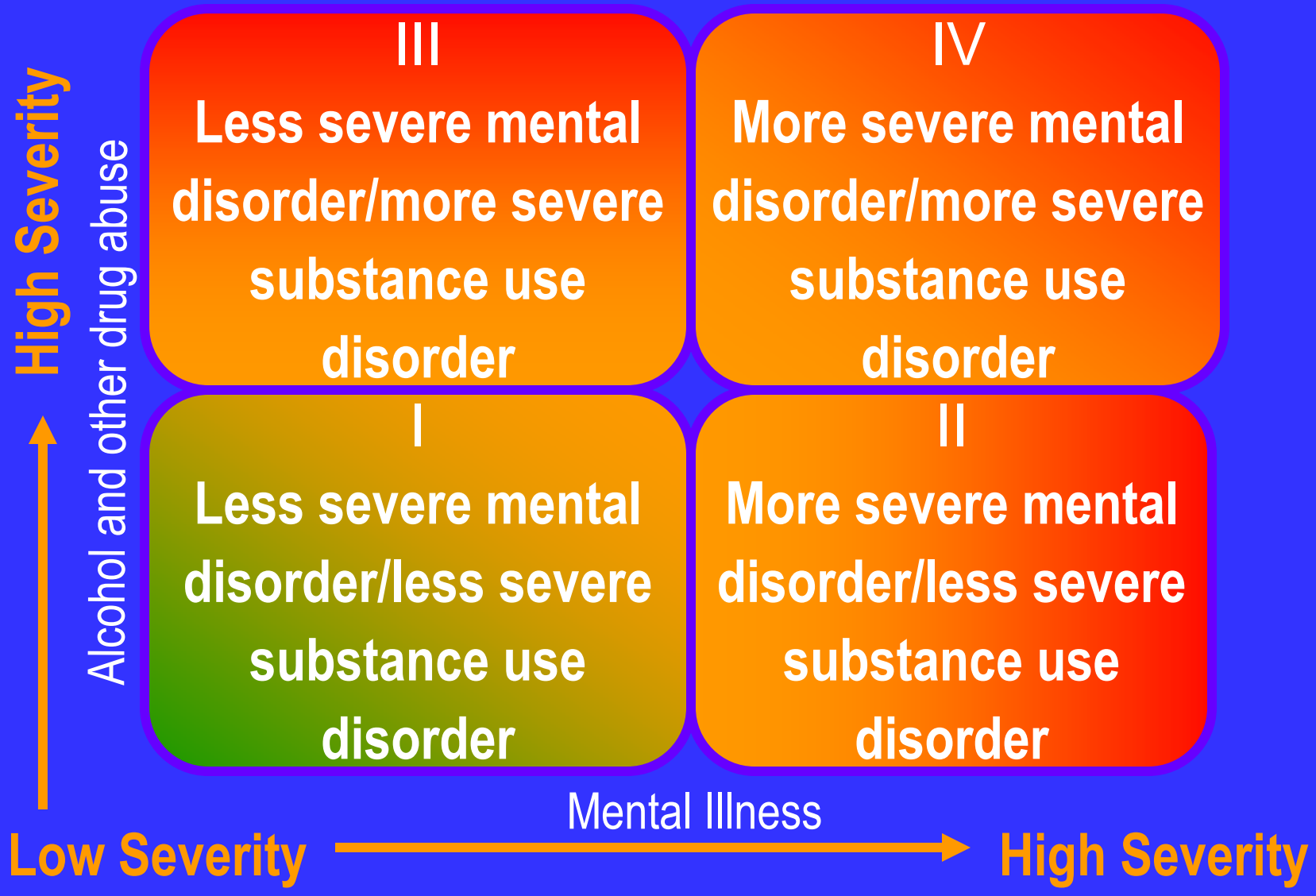
- SAMHSA collaboration with Centers for Medicare and Medicaid Services, in conjunction with Agency for Healthcare Research and Quality
- National Policy Academy on Co-occurring Mental and Substance Abuse Disorders Improve, refine, test and apply consistent outcome measures, *April 2004*
- Improve, refine, test and apply consistent outcome measures
- Disseminate successful strategies for appropriate use of the SAPT and Community Mental Health Services Block Grant

Co-Occurring Collaborations

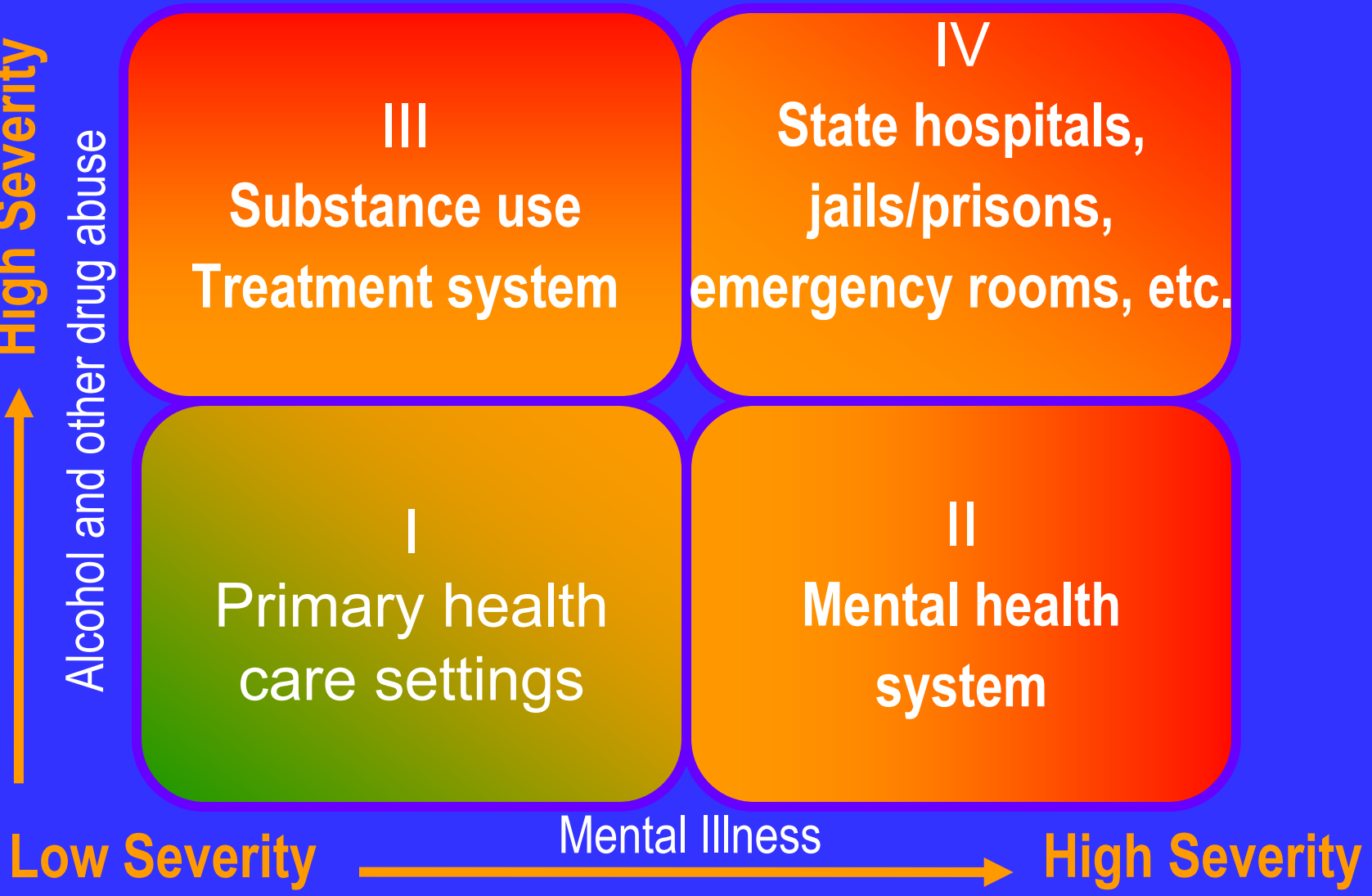
National Dialogue on Co-Occurring Mental Health and Substance Use Disorders

- CSAT, CMHS, NASADAD and NASMHPD national dialogue
- Conceptualizes symptom severity, level of service system coordination on a continuum that ranges from less severe to more severe disorders
- Conceptualizes symptom multiplicity and severity rather than specific diagnoses

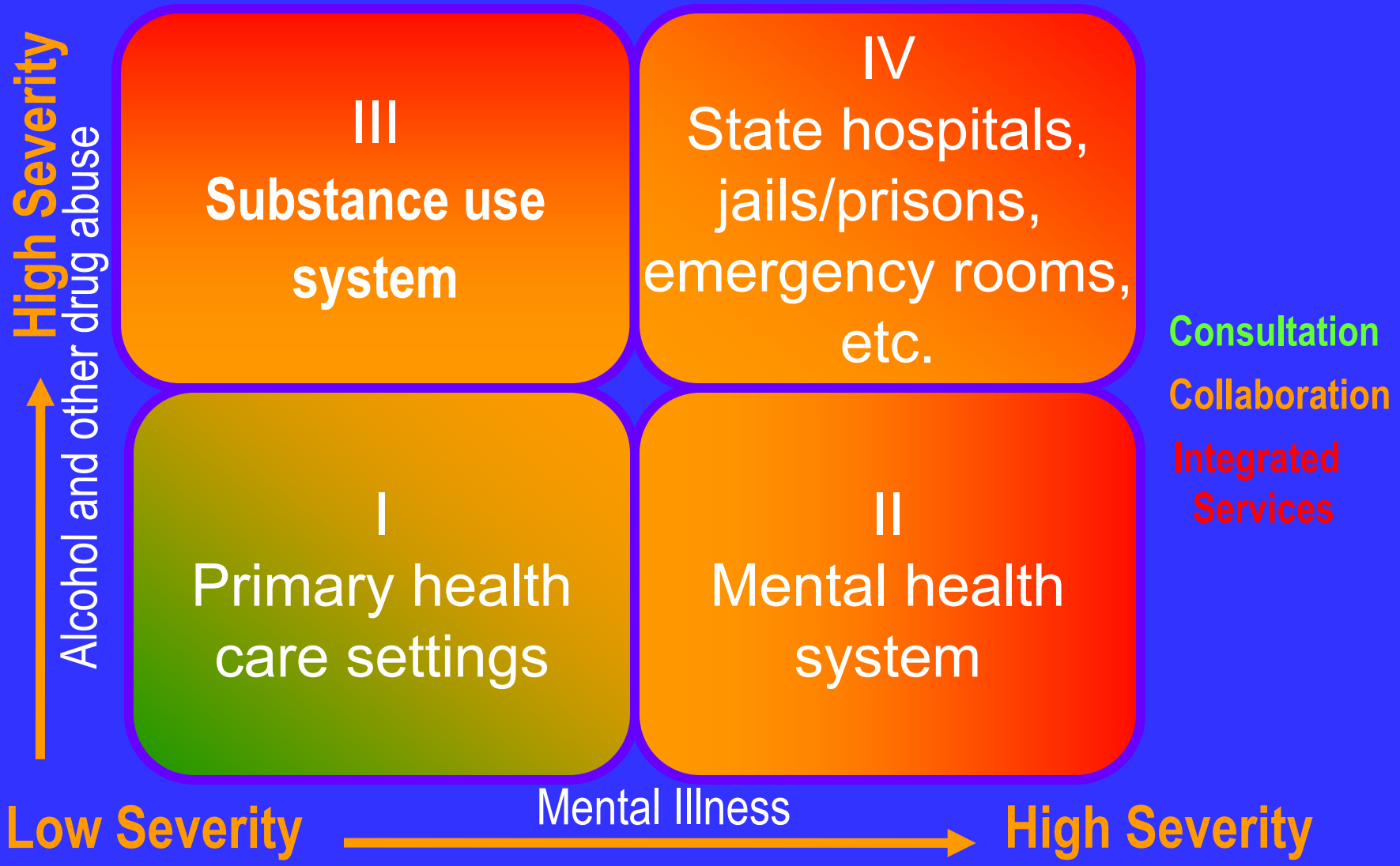
Co-Occurring Disorders by Severity



Primary Locus of Care by Severity



Service Coordination by Severity



Performance Partnership Grants

Redesigned SAPT Block Grant

- Provide states greater flexibility in allocation of Block Grant funds

- Provide greater accountability for outcomes resulting from those decisions

Additional SAMHSA/CSAT Programs

- Targeted Capacity Expansion Grants
  - Address new and emerging trends
  - Allow communities to respond with treatment capacity before problems compound
  - Provide flexibility and agility to meet treatment and treatment system needs
  - Expand capacity for substance abuse treatment

Access to Recovery

Administration's Treatment Initiative

- 3-year $600 million investment in recovery
- First $100 installment is included in the SAMHSA FY 2004 budget approved by Congress
- Use vouchers for the purchase of addiction treatment and recovery support services
- Increases substance abuse treatment capacity

Access to Recovery *cont.*

Administration's Treatment Initiative

- Allows recovery to be pursued in an individualized way, providing consumer choice, the epitome of accountability
- Reward performance by offering financial incentives for providers who produce results
  - Patient success
  - Employment
  - No involvement with criminal justice system

Recovery Community Services Program

- Peer-to-peer recovery support services designed and delivered by peers rather than by professionals.
- Peer services designed and delivered primarily by individuals and families in recovery to meet their recovery support needs, as they define them.
- Therefore, although supportive of formal treatment, peer recovery support services are not treatment in the commonly understood clinical sense of the term.
- While not restricted to clients with COD, such individuals are participating in the $9 million RCSP grant program.

ATTCs

Addiction Technology Transfer Centers

- Upgrade standards of practice and promote addiction treatment in academic programs
- Disseminate the latest science to the treatment community
- Create a multitude of timely and relevant products and services to many disciplines represented by and within the addiction treatment work force

ATTCs, cont.

Addiction Technology Transfer Centers

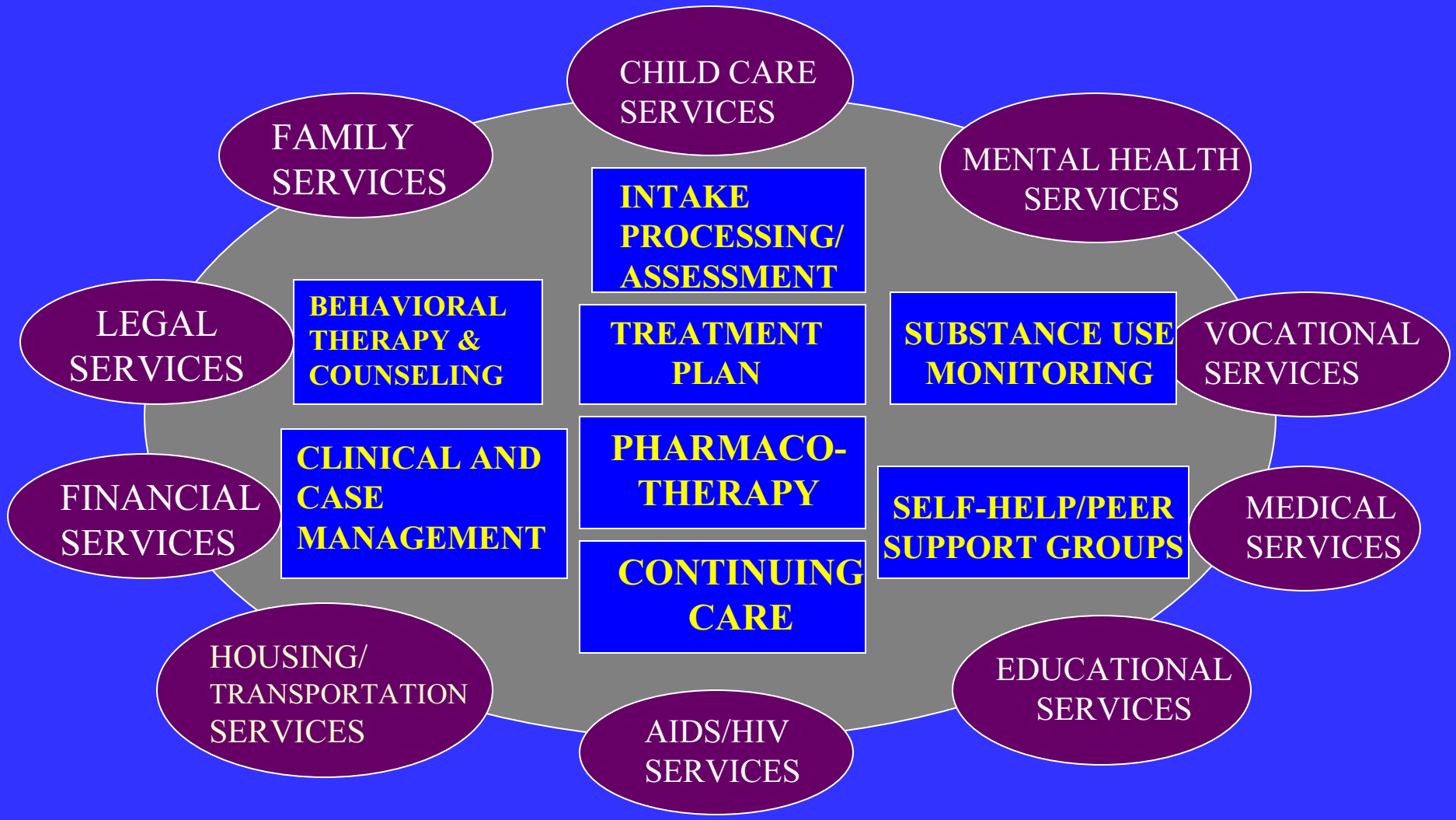
- Help upgrade standards of professional practice for treatment providers
- Prepare practitioners to function in managed care settings
- Promote the inclusion of addiction treatment training in academic programs

ATTCs and Co-Occurring Disorders: Examples of Publications and Trainings

- www.nattc.org/hpsb/cooccurring/attc.html
- Prairielands ATTC offers a master's level online course on Assessment of Substance Related and Mental Health Disorders
- Mid-America ATTC has developed a booklet: "Psychotherapeutic Medications 2003: What Every Counselor Should Know

Components of Comprehensive Drug Abuse Treatment

NIDA's Principles of Drug Addiction Treatment



Comprehensive Treatment assumes an individual treatment plan

SYSTEMS –LEVEL APPROACHES

Systems of care for people with co-occurring disorder must be:

- comprehensive and appear seamless to the client
- Involve multiple systems:
  - Substance abuse - Criminal Justice
  - Mental Health - Social Service
  - Primary Care - Child Welfare

SAMHSA Report To Congress 2002

Integrated Services vs. Integrated Systems

- Integrated Services
  - Designed to improve an individual's access and use of all needed services resources through such techniques as case management.

- Integrated Systems:
  - Designed to change service delivery for a defined population, involving fundamental changes in the way agencies share information, resources and clients.

SAMHSA Report To Congress 2002

Key Precepts of Systems Integration

- Successful systems integration can occur only when a comparable emphasis is placed on integrated services
- Systems integration does not necessarily require the creation of new services or agencies, nor does it require that existing agencies or services be combined.

SAMHSA Report To Congress 2002

Key Precepts of Systems Integration
(continued)

- Systems Integration can be measured by both system-level and client level outcomes
- Systems integration is about improving peoples' lives

SAMHSA Report To Congress 2002

Organizing and Financing a Comprehensive System of Care for People with Co-Occurring Disorders

Key System Development Components	Financing Principles
Provide Leadership/Build Consensus	Define the Population/Plan to Purchase Together
Identify Resources	Secure Financing
Develop New Models/Train Staff	Purchase Effective Services
Decide on Outcomes	Purchase Performance
Evaluate Program	Evaluate and Improve

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEMS OF CARE MODEL (CCISC)

A model for bringing the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process to develop a comprehensive, integrated system of care

CCISC INITIATIVES

State Level

- Alaska
- Arizona
- District of Columbia
- Maine
- Maryland
- New Mexico
- Vermont
- CO-SIG (LA, HI, AK, PA)

Network Level

- Mid-Valley Behavioral Care Network, Oregon
- Mental Health Systems, California
- Southwest Counseling, Michigan

City/County Level

- San Diego County, California
- Birmingham, Alabama
- Lynchburg, Virginia
- Kent County, Michigan
- Detroit, Michigan
- Bay City, Michigan
- Tampa, Florida
- Broward County, Florida
- Victoria, British Columbia
- Winnipeg, Manitoba
- Worcester County, Maryland
- Blair County, Pennsylvania

CCISC Model

- Four Basic Characteristics
- Eight Principles of Treatment
- Twelve Steps of Implementation

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Four Basic Characteristics of CCISC

1. System Level Change
2. Efficient Use of Existing Resources
3. Incorporation of Best Practices
4. Integrated Treatment Philosophy

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Eight Principles of Treatment CCISC

1. Dual diagnosis is an expectation, not an exception
2. All people with COD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders can be used as a guide for service planning on the system level.
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties

Eight Principles of Treatment CCISC

4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery),

Eight Principles of Treatment CCISC

7. There is no single correct intervention for COD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.
8. Clinical outcomes for COD must also be individualized, based on similar parameters for individualizing treatment interventions

Twelve Steps of Implementation of CCISC

1. Integrated system planning process
2. Formal consensus on CCISC model
3. Formal consensus on funding the CCISC model
4. Identification of priority populations, and locus of responsibility for each
5. Development and implementation of program standards
6. Structures for intersystem and interprogram care coordination

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Twelve Steps of Implementation of CCISC

7. Development and implementation of practice guidelines
8. Facilitation of identification, welcoming, and accessibility
9. Implementation of continuous integrated treatment
10. Development of basic dual diagnosis capable competencies for all clinicians
11. Implementation of a system wide training plan
12. Development of a plan for a comprehensive program array

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Identify and Fill System Gaps

- **Evidence based best practice**
- **Peer dual recovery supports**
- **Residential supports and services**
- **Continuum of levels of care**

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Treatment Matching

In a **managed care system**, individualized treatment matching also requires multidimensional level of care assessment involving **acuity**, **dangerousness**, **motivation**, **capacity for treatment adherence**, and availability of continuing empathic treatment relationships and other recovery supports.

COD CAPABLE

- Routinely Accepts COD Patient
- Welcoming Attitudes to Co-Morbidity
- **CD PROGRAM:** MH Condition Stable and Patient can participate in treatment
- **MH PROGRAM:** Coordinates Phase-Specific Interventions for any Substance DX.
- Policies and Procedures Routinely Look at COMORBIDITY in Assessment, RX PLAN, DX PLAN, Programming
- Care Coordination around Medications (CD)

COD Capable: Chemical Dependency

- Routinely accepts dual patients, provided:
- Low MH symptom acuity and/or disability, that do not seriously interfere with CD Rx
- Policies and procedures present re: dual assessment, rx and d/c planning, meds
- Groups address comorbidity openly
- Staff cross-trained in basic competencies
- Routine access to MH/MD consultation/coord.
- Standard addiction program staffing level/cost

COD Capable: Mental Health

- Welcomes active substance users
- Policies and procedures address dual assessment, rx & d/c planning
- Assessment includes integrated mh/sa hx, substance diagnosis, phase-specific needs
- Rx plan: 2 primary problems/goals
- D/c plan identifies substance specific skills
- Staff competencies: assessment, motiv.enh., rx planning, continuity of engagement
- Continuous integrated case mgt/ phase-specific groups provided: standard staffing levels

COD ENHANCED (COD-E)

MEETS COD CRITERIA PLUS:

CD: Modification to Accommodate MH Acuity OR Disability

MH Specific Programming, Staff, and Competencies, including physicians

Flexible Expectations; Continuity

MH: Addiction Treatment in Psych Managed Settings (COD INPT Unit) OR

Intensive Case Management/outreach to Most Seriously MI AND Addicted People

COD Enhanced: CD

- Meets criteria for COD-CD, plus:
- Accepts moderate MH symptomatology or disability, that would affect usual rx.
- Higher staff/patient ratio; higher cost
- Braided/blended funding needed
- More flexible expectations re:group work
- Programming addresses mh as well as dual
- Staff more cross-trained/ senior mh supervision
- More consistent on site psychiatry/psych RN
- More continuity if patient slips

COD Enhanced: Mental Health

- Meets all criteria for DDC-MH, plus:
- Supervisors and staff: advanced competencies
- Standard staffing; specialized programming:

  a. Intensive addiction programming in psychiatrically managed setting (dual inpt unit; dry dual dx housing, supported sober house)

  b. Range of phase-specific rx options in ongoing care setting: dual dx day treatment; damp dual dx housing

  c. Intensive case mgt outreach/motiv. enh.: CTT, wet housing, payeeship management

SYSTEM FEATURES

- All systems are complex with unique structures and cultures
- All systems work within the context of limited resources and with complex funding issues
- Data is often inconsistent with epidemiologic findings
- Each has significant strengths and weaknesses at all levels (system, program, clinical practice, and clinician)
- Under utilization of leverage (carrots and sticks)
- Everyone falls into the training trap at some point
- Each is becoming more sophisticated about outcomes measurement (system and clinical) and continuous quality improvement approaches

PUBLIC BEHAVIORAL HEALTH CARE SYSTEMS ISSUES

- Multiple State Agencies and Governing Bodies
- Multiple Funding Streams
- Multiple Systems of Care
- Severely Limited Resources
- Poverty
- Rural and Urban
- Cultural Diversity

Identification of Need

- Morbidity and Mortality
- Gross Under Identification
- Inefficient Use of Resources
- Unmet Needs

Consequences of Substance Use in Patients with Psychosis

- Increased Psychotic Symptoms
- Reduced Treatment Compliance
- High Relapse Rates
- Frequent Use of Health Care Services
- Increased rates of Tardive Dyskinesia
- Early Mortality
- Suicide
- Housing Instability
- Homelessness
- Violent Behavior
- Criminal Behavior
- Increase Family Conflict

Lubman & Sundram, MJA Vol 178:S71-S75, (2003)

Clinician Attitudes About Substance Use And COD

- The hazards of excessive alcohol use, cigarette smoking and the use of illicit substances notwithstanding, clinician attitudes about use of such substances will influence whether appropriate diagnosis or referrals will be made

Paradoxical Attitudes about Substance Use

"Toxicology screening: Routine use of urine or other screening for all new mental health clients may be both costly and intrusive."

Written comments in a draft report on Co-Occurring Disorders that acknowledged a high percentage of substance use among clients who have Serious Mental Illness

Questions for Hawaiian Mental Health Providers

Do State Laws Permit Public Mental Health Dollars To Pay For:

- Treatment of COD
- Treatment of Primary Substance Abuse

Examples of Public Mental Health Systems that Prioritize for Serious and Persistent Mentally Ill over Non-SPMI Mentally Ill

- Hawaii
- Maine
- Missouri
- Illinois
- Alaska
- Wyoming
- Maryland
- Colorado

STRATEGIC ALIGNMENT

- CCISC – Principle-driven Systems Improvement Approach
- CCISC – Supports Implementation of Evidence-based Approaches and Improves Routine Practices
- CCISC – Can be Implemented with Existing Resources Using Traditional Funding Streams

IMPLEMENTATION OF CCISC

- Top-down/Bottom-up Development
- Aligning the Parts of the System
- Inclusion, not Exclusion (programs and populations)
- Strategic Use of Leverage (Incentives, Contracts, Standards, Licensure, etc.…)
- Outcomes and CQI

IMPLEMENTATION OF CCISC
(continued)

- Model Programs
- Evaluation of Core Competencies
- “Action Planning”
- Train-the-Trainers

STARTING PLACES

- Identification of the Population in Need
- Administrative Barriers
- Universal Integrated Screening
- Assessment Process
- Treatment Matching
- Treatment Planning
- Engagement, Stage of Change and Contingency Management
- Evaluation of Trauma
- Interagency Coordination

PRINCIPLES OF SUCCESSFUL TREATEMENT

- Co-morbidity is an expectation, not an exception.
- Treatment success derives from the implementation of an **empathic, hopeful, continuous** treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.
- Within the context of the empathic, hopeful, continuous, integrated relationship, **case management/care** and **empathic detachment/ confrontation** are appropriately balanced at each point in time.

PRINCIPLES OF SUCCESSFUL TREATEMENT

(continued)

- When substance disorder and psychiatric disorder co-exist, each disorder should be considered **primary**, and **integrated dual primary treatment** is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.
- Both major mental illness and substance dependence are examples of primary mental illnesses which can be understood using a **disease and recovery model**, with parallel **phases of recovery**, each requiring **phase-specific treatment**.

PRINCIPLES OF SUCCESSFUL TREATEMENT

(continued)

- ***There is no one type of dual diagnosis program or intervention***. For each person, the correct treatment intervention must be individualized according to diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder, and level of **acuity**, **dangerousness**, **motivation**, **capacity for treatment adherence**, and availability of continuing empathic treatment relationships and other recovery supports.

Evidence-Base for CCISC

- It is important to recognize that CCISC itself in not an evidence based practice, but an exemplary model based on evidence based practices.
- This model includes work derived from the Clinical Standards and Workforce Competencies Project developed by CMHS

Evidence-Based Practices for COD

- Traditional Definition of Evidence-Based Practice
  - Gold Standard
    - Assessment of research findings from randomized, controlled clinical trials
  - Next Best
    - Quasi-experimental study in which comparison groups are assigned by randomization
  - Weak Design
    - Open Clinical Trials coupled with expert-based clinical observations

Limited Evidence in the Treatment of COD

"Controlled research on the treatment of dual diagnosis is limited, and the results are inconclusive, but there are some promising findings."

Harvard Mental Health Letter, Vol 20: September 2003,
See also, Report to Congress (2002)

IOM Less Stringent View of Evidence Based Practice

An evidence based practice is the integration of the following critical elements:

- Best research evidence
- Clinical Expertise
- Patient Values

SAMHSA Report to Congress 2002

Cautious Optimism for Integrated Treatment for COD

- Drake et al (1998) reviewed 36 research studies on the effectiveness of integrated treatment in mental health settings for people with COD.
- Drake et al concluded: “Integrated treatment, especially when delivered for 18 months or longer, resulted in significant reductions in substance abuse, and, in some cases, in substantial rates of remission, as well as in reductions in hospital use and/or improvements in other outcomes.”

Drake et al, Schizophrenia Bulletin 24:589-305

Randomized Controlled Trial of Motivational Interviewing, Cognitive Behavior Therapy, and Family Intervention for Patients With Co-morbid Schizophrenia and Substance Use Disorders

- The authors conducted a randomized, single-blind controlled comparison of routine care with a program of routine care integrated with motivational interviewing, cognitive behavior therapy, and family or caregiver intervention

Barrowclough et al,
Am J Psychiatry 158:1706-1713, October 2001

Barrowclough et al found that:

The integrated treatment program resulted in significantly greater improvement in patients' general functioning than routine care alone at the end of treatment and 12 months after the beginning of the study. Other benefits of the program included a reduction in positive symptoms and in symptom exacerbations and an increase in the percent of days of abstinence from drugs or alcohol over the 12-month period from baseline to follow-up.

SAMHSA Report to Congress 2002

COD Treatment Strategies with some Evidence Base

- Motivational Interventions
- Cognitive/Behavioral Approaches
- Modified Therapeutic Communities
- Assertive Community Treatment (ACT)
- Intensive Case Management
- Contingency Management

CSAT TIP 2004 (in press)

Recovery Month

National Alcohol and Drug Addiction Recovery Month

- Americans at all levels of society and in all professions can work to enhance addiction treatment program access, availability and quality
- *2004 Theme: Join the Voices for Recovery: Now!*

www.recoverymonth.gov

SAMHSA Report to Congress on The Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders

http://www.samhsa.gov/reports/co_occur_home.htm

President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America

http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html

www.samhsa.gov

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